ABP-80-0456-0200

STATE OF NEW JERSEY
DEPARTMENT OF THE TREASURY - DIVISION OF PENSIONS AND BENEFITS

PO Box 295
Trenton, NJ
08625-0295

Alternate Benefit Program
Application for Transfer

This application must be completed by all Alternate Benefit Program participants transferring locations and continuing their Alternate Benefit Program participation.

PART I: To be completed by the employee. (Please print)

I, _____, ABP Membership No. _____
(assigned by Division of Pensions)

resigned my position as _____ at _____

on the _____ day of _____ , 20 __ . I hereby notify the Division of Pensions that I have accepted

employment at _____ and request that the Division continue my

participation in the Alternate Benefit Program at this new location.

IMPORTANT: ***Any change which you wish to make in beneficiaries or in TIAA/CREF deductions must be made on the appropriate change forms which may be obtained from your benefits officer. If you had a Salary-Reduction Agreement with your former employer and wish to continue the reduction, you must sign a new agreement with your new employer.***

PART II: To be completed by your new employer.

1. Employee's Title: _____
2. Appointment Date: _____
3. Full-Time Employee: ☐ Yes ☐ No
4. Employed: ☐ Ten ☐ Twelve Months
5. Social Security No.: _____
6. Annual Base Salary: $ _____
7. Location or Payroll No.: _____

I certify that this employee is a full-time permanent employee eligible under the rules and regulations of the Department of Higher Education, for participation in the Alternate Benefit Program.

_____ _____
Signature of Certifying Officer *Title*

_____ _____
Institution *Date*